Place label Here

Photo ID Verified ❑

PLEASE PRINT

Date of First Appointment____________________
Location____________________

Patient's Name: ______________________________ Home Phone # ____________

Address: ______________________________ Cell Phone # ____________
Street City State Zip

E-Mail Address: ______________________________ Best number for messages: Home ❑ Cell ❑

Date of Birth:__________ SEX: Male ❑ Female ❑ Non-binary ❑ Relationship Status:__________ Social Security # _ _ _ _ (last 4 digits)

Have you or any other family members received medical care by our practice? If so, Who:__________ When: __________

EMERGENCY CONTACT:__________ Relationship:__________ Contact Phone # __________

Primary Care Physician: ______________________________ Phone ( ) __________

Group Name: ______________________________

Address: ______________________________ Fax # ( ) __________
Street City State Zip

Specialist/Other: ______________________________ Phone ( ) __________

Address: ______________________________ Fax # ( ) __________
Street City State Zip

Written report(s) will be sent to above Physicians unless otherwise noted; I give permission, PCP: Yes ❑ No ❑ Specialist/Other: Yes ❑ No ❑

How did you first hear about Colorado Allergy and Asthma Centers? (Check One)

❑ Primary Care: as above
❑ Specialist: as above
❑ Insurance Company
❑ Internet Search
❑ Advertisement
❑ Radio
❑ Google®
❑ CAAC Patient __________
❑ Family Member __________
❑ Friend __________
❑ Other __________
____

Patient OR parent/guardian of a minor

Name: __________ Relationship: __________

Date of Birth: __________ SSN # __________

E-mail Address: __________

Employer: __________ Phone # __________

Employer Address: __________

City: __________ State:______ Zip: __________

Spouse/Significant other OR the second parent/ guardian of a minor

Name: __________ Relationship: __________

Date of Birth: __________ SSN # __________

E-mail Address: __________

Employer:__________ Phone #__________

Employer Address: __________

City: __________ State:______ Zip: __________

INSURANCE INFORMATION (Primary)

Ins Company:__________ Phone # __________

Policy Holder/Subscriber: __________

SEX: Male ❑ Female ❑

Subscriber Address: __________

Subscriber Date of Birth: __________ SSN # __________

Subscriber Relationship: __________

Ins Address: __________

Member/ID #__________ Group: __________

I have no insurance ❑

INSURANCE INFORMATION (Secondary)

Ins Company:__________ Phone # __________

Policy Holder/Subscriber: __________

SEX: Male ❑ Female ❑

Subscriber Address: __________

Subscriber Date of Birth: __________ SSN # __________

Subscriber Relationship: __________

Ins Address: __________

Member/ID #__________ Group: __________

I authorize the release of any information necessary to process claims. I request payment of benefits to Colorado Allergy and Asthma Centers. I understand I am financially responsible for charges not covered by this authorization.
I understand and agree if care at Colorado Allergy and Asthma Centers requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Colorado Allergy and Asthma Centers. If no referral is present in advance, I agree to pay for charges.

Patient/Guardian Signature ______________________________ Relationship to Patient __________

Witness ______________________________ Date __________

Consent for care of minors

Because my son/daughter is a minor (less than eighteen (18) years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Colorado Allergy and Asthma Centers' staff if I am not present to give consent. This may include, but necessarily limited to, physical exams, skin tests, laboratory test, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature ______________________________ Relationship to Patient __________

Witness ______________________________ Date __________

Colorado Allergy and Asthma Centers, P.C. **New Patient History**

Complete the following information. Please put an **X** in each box that relates to your problems. Use additional page to answer any questions if more room is needed.

Patient Name: ______________________________ Date of Birth: __________ Date of First Visit: __________
(Please Print)

Were you referred by a physician or other provider? ☐ no ☐ yes If yes, who ______________________

Briefly state what problems are bringing you here: ______________________________

Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems

Note: If No UPPER Respiratory Tract problems, Check Here ☐ And Go To Page 2 - Lower Respiratory Tract.

When did these symptoms first begin? ______________

☐ sneezing ☐ itching nose ☐ runny nose
☐ nasal congestion ☐ stuffiness ☐ post-nasal drip
☐ decreased or absent sense of smell
☐ nose bleeds ☐ snoring
☐ nasal polyps; if so: ☐ past ☐ present
☐ drainage cough ☐ sore throat
☐ itchy throat ☐ bad breath
☐ frequent colds; if so, how many per year? 1-5 ☐ 5-10 ☐
☐ headaches/sinus pain ______________
☐ recurrent ear infections ☐ ear plugging/popping/fullness
☐ hearing loss ☐ dizziness
☐ septum deviated ☐ septum perforated

☐ previous nasal or sinus surgery
☐ recurrent or chronic sinus infections; if so, how many per year?
☐ 0-4 ☐ over 4
☐ sinus x-rays or sinus CT scan done
- if so, when? ______________
- result ☐ normal ☐ abnormal

☐ ENT evaluation; if so, when? ______________
- name of doctor: ______________

Eyes: ☐ itch ☐ red ☐ watering ☐ swollen lids
☐ dark circles ☐ fatigue/tired ☐ poor concentration
☐ other: ______________

Symptoms Caused Or Aggravated By:

☐ cold air ☐ weather
☐ odors/scents/fragrance ☐ tobacco smoke
☐ dusting/vacuuming ☐ musty odors/mold
☐ yard work/pollens ☐ being outdoors
☐ aspirin/related medications
☐ animals, list: ______________
☐ other: ______________

Year-round symptoms? ☐ yes ☐ no

Season(s) in which symptoms are **worst**: ("X" all that apply)
☐ spring ☐ summer ☐ fall ☐ winter

Symptoms worse: ☐ AM ☐ PM ☐ night

Symptoms interfere with: ☐ sleep ☐ exercise/activity ☐ missed school ☐ missed work

Symptoms are: ☐ improving ☐ worsening ☐ unchanged

List medications tried for **nose/sinus** symptoms (include prescription and over-the-counter oral medications and nasal sprays):

Current Medication	Does it work?	Past Medication	Did it work?
______	☐ yes ☐ no	______	☐ yes ☐ no
______	☐ yes ☐ no	______	☐ yes ☐ no
______	☐ yes ☐ no	______	☐ yes ☐ no
______	☐ yes ☐ no	______	☐ yes ☐ no
______	☐ yes ☐ no	______	☐ yes ☐ no

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9/10 (Form #105)

Name____

Lower Respiratory Tract (Chest, Lung) Problems

Note: If No LOWER Respiratory Tract Problems, Check Here ❑ And Go To Page 3.

When did chest symptoms first begin? ____________________

❑ chronic or recurrent cough ❑ coughing spells

❑ dry ❑ loose; is mucus coughed up? ❑ yes ❑ no

- if yes, is mucus colored? ____________________

❑ coughing up blood

❑ wheezing; when breathing ❑ out ❑ in

❑ chest tightness or pressure ❑ throat tightness

❑ shortness of breath ❑ difficulty taking a full breath

❑ cough or breathing problems interfer with sleep

❑ asthma diagnosed by a physician? Age:______________

❑ emergency room visit(s) for asthma; how many?__________

❑ hospitalized for asthma; how many?____________________

❑ intensive care unit for asthma

❑ oral steroids (Prednisone, Medrol, Prednisolone) taken for asthma

- if so, number of times taken per year:
  ❑ 1 ❑ 2 - 3 ❑ greater than 3
- date of last use: ______________________________

❑ history of recurrent bronchitis

❑ history of recurrent pneumonia

❑ history of recurrent croup

❑ previous chest x-ray or chest CT scan; if so, when?________

- result: ❑ normal ❑ abnormal

❑ peak flow meter used; if so, best reading:______________

❑ pulmonary function (lung) test: ❑ yes ❑ no

❑ pulmonary (lung specialist) evaluation; when: ___________

- specialist's name: ______________________________

❑ Are you physically active on a regular basis (formal exercise, play sports, other types of physical activity)? ❑ yes ❑ no

❑ Do you experience a cough, wheeze, difficulty breathing during exercise/physical activity? ❑ yes ❑ no

❑ other symptoms (list): ____________________________

____

____

____

____

Symptoms Caused Or Aggravated By:

❑ colds / upper respiratory infections ❑ sinus infections

❑ exertion / exercise; type:____________________

❑ cold air ❑ weather change

❑ odors / scents / fragrance ❑ tobacco smoke

❑ eating / drinking ❑ heartburn / acid reflux

❑ emotional stress / anger ❑ laughing / crying / cough

❑ your workplace or school ❑ aspirin / related medications

❑ dusting / vacuuming ❑ musty odors / mold

❑ yard work / pollens ❑ being outdoors

❑ animals, list:______________________________

❑ other:__________________________________

Year-round symptoms? ❑ yes ❑ no

Season(s) in which symptoms are **worst**: ("X" all that apply)

❑ spring ❑ summer ❑ fall ❑ winter

Symptoms interfere with: ❑ sleep ❑ exercise / activity ❑ missed school ❑ missed work

Symptoms are: ❑ improving ❑ worsening ❑ unchanged

List medications tried for **lower respiratory** symptoms (include prescription and over-the-counter oral, inhaled, and injected medications):

Albuterol ❑ inhaler ❑ nebulizer How often used?____________________

Current Medication	Does it work?	Past Medication	Did it work?
____________	❑ yes ❑ no	____________	❑ yes ❑ no
____________	❑ yes ❑ no	____________	❑ yes ❑ no
____________	❑ yes ❑ no	____________	❑ yes ❑ no
____________	❑ yes ❑ no	____________	❑ yes ❑ no
____________	❑ yes ❑ no	____________	❑ yes ❑ no

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Name:______________________________

Skin Problems

Note: If No SKIN Problems, Check Here ❑ And Go To 'Previous Allergy Evaluation' below.

Skin Symptoms:

❑ eczema ❑ rash

When did skin/eczema symptoms first begin? ______________

❑ itching ❑ excessively dry, scaly skin

❑ irritated red patches ❑ weepy, oozing rash

❑ recurrent skin infections

❑ welts/hives ❑ skin swelling

When did hives/swelling first begin? ______________

❑ itching ❑ face swelling ❑ hand/foot swelling

❑ lip swelling ❑ tongue /throat swelling

❑ difficulty breathing from swelling

❑ other skin symptoms (list):______________________________

Location of eczema/rash/hives: ❑ arms ❑ legs ❑ trunk ❑ head ❑ neck

Frequency of above symptoms: ❑ daily ____ times per week ____ times per month ❑ other:______________

Do skin symptoms occur year-round? ❑ yes ❑ no

Season(s) in which above skin symptoms are worst: ❑ spring ❑ summer ❑ fall ❑ winter

Has a physician diagnosed your rash? ❑ yes ❑ no

- if yes, what was the diagnosis? ❑ hives ❑ eczema ❑ contact dermatitis ❑ other:______________

Have you seen a dermatologist for your skin problems? ❑ yes ❑ no

- if yes, name of doctor:______________________________ when seen:______________

List everything that causes or aggravates your skin symptoms:

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

List medications tried for **above** symptoms (include prescription and over-the-counter oral medications, creams, and ointments):

Current Medication	Does it work?	Past Medication	Did it work?
______________	❑ yes ❑ no	______________	❑ yes ❑ no
______________	❑ yes ❑ no	______________	❑ yes ❑ no
______________	❑ yes ❑ no	______________	❑ yes ❑ no
______________	❑ yes ❑ no	______________	❑ yes ❑ no

Previous Allergy Evaluation(s): ❑ no ❑ yes Date(s):______________

Skin testing: ❑ no ❑ yes Blood testing for allergy: ❑ no ❑ yes Were you allergic? ❑ no ❑ yes

- if allergic, was it to: ❑ animals ❑ dust/mites ❑ pollen ❑ mold ❑ food ❑ other (list):______________

Allergist: Name: ______________________________ State:______________

Previous allergy injection(s): ❑ no ❑ yes If yes, age or date(s) of treatment: ______________

If yes, how long did you take shots? ❑ 6 month ❑ 1 year ❑ 2 years ❑ 3 years ❑ longer

- were allergy injections effective? ❑ no ❑ yes ❑ not sure
- adverse reactions to allergy injection(s)? ❑ no ❑ yes If yes, list:______________

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____
____

Name:____

Insect Sting Reactions: ☐ no ☐ yes If yes, insect(s) causing reaction: ______________________________

- symptoms: ☐ large swelling at site ☐ hives ☐ breathing problems ☐ dizzy / lightheaded
  ☐ other (list): ______________________________
- age or date when occured?______________ (Epi-Pen) Epinephrine/Adrenalin device prescribed? ☐ no ☐ yes

Drug Allergies / Intolerances: ☐ no ☐ yes

Name Or Type Of Medication	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Medication Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Food Allergies / Intolerances: ☐ no ☐ yes

Food	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Food Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Latex or Rubber Allergies / Intolerances: ☐ no ☐ yes

If yes, explain: ______________________________

Past Medical History:

Flu vaccine: ☐ no ☐ yes Pneumonia vaccine: ☐ no ☐ yes T.B. test: ☐ no ☐ yes result: ☐ positive ☐ negative

Birth history (if patient is a child): ☐ normal ☐ premature ☐ problems at birth:______________________________

Hospitalization(s): ☐ none ______________________________

Surgery(s): ☐ none ______________________________

Serious injury(s): ☐ none ______________________________

Other medical problems: ______________________________

All Current Medications not already listed (Include Over-The-Counter and Supplements. Use additional page if necessary.)

Medication	Dosage	Frequency (how often)	Medication	Dosage	Frequency (how often)

Family History:

Do any close family members have the following? **Check the appropriate box below:** (even if <u>mild</u> or <u>outgrown</u>)

	Father	Mother	Brothers	Sisters	Children
Hay fever / Allergies	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Sinus trouble	☐	☐	☐	☐	☐
Migraine headache	☐	☐	☐	☐	☐

Other diseases that run in the family:

Immune problems ☐ yes ☐ no
Family member: ______________

Cystic Fibrosis ☐ yes ☐ no
Family member: ______________

Emphysema ☐ yes ☐ no
Family member: ______________

Name:____

Social History:

Has the patient ever smoked? ☐ no ☐ yes If yes, for how many years: ____________________

Current smoker? ☐ yes ☐ no If no, when did you quit: ____________________

- how much do/did patient smoke? Number of packs per day ☐ less than 1/2 ☐ 1/2 ☐ 1 ☐ 2 or more

Alcoholic beverages? ☐ no ☐ yes If yes, how often: ____________________

Marijuana or other "recreational" drugs? ☐ no ☐ yes If yes, how often: ____________________

Review of Systems: (check all that applies)

General

☐ Good general health

☐ Weight gain; past year: ________lbs.

☐ Weight loss: _________lbs.

- dieting ☐ yes ☐ no

☐ Excessive tiredness

☐ Excessive thirst / drinking

☐ Recurrent fever

☐ Recurrent night sweats

☐ Pregnant

☐ Planning pregnancy within year

☐ Cancer history

- type: ____________________

Eyes ☐ Does not apply

☐ Dry eyes

☐ Wear contact lenses

☐ Cataracts

☐ Glaucoma

Mouth / Throat ☐ Does not apply

☐ Excess dryness of mouth

☐ Excessive throat mucus*

☐ Throat clearing*

☐ Hoarseness or voice problems*

☐ Sensation of something stuck in throat*

Heart ☐ Does not apply

☐ Palpitation or pounding of heart

☐ Irregular heart beat

☐ Angina / chest pain / tightness

☐ History of heart attack

☐ Thrombophlebitis / blood clots

☐ Swollen ankles / feet

☐ Heart murmurs

☐ High blood pressure

Gastrointestinal ☐ Does not apply

☐ Difficulty swallowing*

☐ Heartburn / acid indigestion / reflux

- stomach acid coming up*
- frequency:____________________
- treatment:____________________

☐ History of ulcer

☐ Frequent spitting up or wet burps (infants)

☐ Hiatal hernia

☐ Recurrent vomiting

☐ Frequent diarrhea

☐ Bloody or black stools

☐ Constipation

☐ Liver disease: ____________________

☐ History of Hepatitis

- Hepatitis Type: ☐ A ☐ B ☐ C
- if so, when diagnosed______________

☐ Other problems: ____________________

____

☐ GI specialist: ____________________

- when: ____________________

Genitourinary ☐ Does not apply

☐ Frequent urination

☐ Kidney trouble

☐ Bladder infection

☐ Prostate problem (men)

☐ Kidney stones

Musculoskeletal ☐ Does not apply

☐ Painful or stiff joints

☐ Swollen joints

☐ Rheumatoid Arthritis

☐ Osteoarthritis (age / injury related)

☐ Osteoporosis

☐ Osteopenia

☐ Bone Density Test

- date: ____________________

Endocrine ☐ Does not apply

☐ Thyroid gland problems

☐ Adrenal gland problems

☐ Diabetes

☐ Parathyroid disease

Neurologic ☐ Does not apply

☐ Sinus headache

☐ Migraine headache

☐ Tension headache

☐ Hyperactivity / ADD / ADHD

☐ Dizzy spells

☐ Fainting spells

☐ Convulsions / epilepsy / seizures

☐ Sleep Apnea

☐ Insomnia

☐ Depression

☐ Anxiety

☐ Ever see a psychiatrist / psychologist?

☐ Currently see one

Blood / Lymphatic ☐ Does not apply

☐ Blood disorder: ____________________

☐ Anemia

☐ Bruise easily

☐ Swollen lymph nodes ______________

☐ Previous blood transfusion

☐ Risk factors for AIDS

☐ Testing for HIV

- if so, result: ☐ positive ☐ negative

☐ **Other symptoms or medical problems** (list)

____

____

____

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____

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____

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____

____

____

ROS reviewed with patient/parent

MD/PA Initials___________

Name:____

Environmental History

How long has patient lived in Colorado?________________ What other states/countries has patient lived in? ____________________

Primary Home (for patient living in two homes, also complete "Second Home" below)

Type: ☐ house ☐ townhouse ☐ condominium ☐ apartment ☐ mobile home ☐ other: ____________________

Age of home: ☐ less than 10 years ☐ 10-20 years ☐ 20-50 years ☐ over 50 years Length of time in home:_________

Construction

Basement: ☐ none ☐ finished ☐ unfinished ☐ walkout ☐ dirt ☐ crawl space ☐ moisture problem

Heating and Cooling

Heat: ☐ forced air heat ☐ hot water or radiant heat ☐ electric heat ☐ woodburning stove ☐ Fireplace; ☐ wood ☐ gas

Cooling system: ☐ none ☐ central air ☐ window air conditioner ☐ swamp cooler ☐ attic fan

Central filter type: ☐ none ☐ fiberglass ☐ HEPA ☐ electrostatic Frequency of filter change or cleaning: ____________

Room air filter: ☐ none ☐ HEPA ☐ electrostatic ☐ ion generator ☐ other:__________ • which room_________

Air Ducts cleaned: ☐ no ☐ yes If yes, when____

Mold and Moisture

Humidifier: ☐ none ☐ furnace ☐ cold-mist ☐ ultrasonic ☐ steam

Water leak(s): ☐ none ☐ past ☐ current ☐ musty odor ☐ visible mold

Cleaning

Frequency of dusting: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Frequency of vacuuming: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Patient's Bedroom

Flooring: ☐ carpet ☐ wood ☐ tile ☐ linoleum ☐ area rug

Bed: Mattress: ☐ innerspring ☐ foam ☐ waterbed ☐ bunk ☐ futon

Pillow: ☐ feather (down) ☐ foam ☐ synthetic

Pets

☐ no ☐ yes

	Number	How Long Owned?	Type / Breed	Outside	Inside	Sleep in Bedroom
☐ Dog(s)	______	______________	______________	☐	☐	☐
☐ Cat(s)	______	______________	______________	☐	☐	☐
☐ Other(s)	______	______________	______________	☐	☐	☐

Smokers (at your home)

☐ No one ☐ patient ☐ mother ☐ father ☐ husband ☐ wife ☐ other

Other Environments

Daycare: Number of days per week______________ ☐ Animals Number in room________

Relatives' Homes: Number of days per week______________ ☐ Animals ☐ Smokers

School / Work: Number of days per week______________ ☐ Animals ☐ Smokers

Hobbies / Interests

____

Occupation / School / Daycare

Type of work / school / daycare: ____

Kinds of materials exposed to at work / school: ______________________________________

Second Home (for patient living in two homes, please complete the following):

Time spent in second home: ____

Smokers:______________________________________

Pets:______________________________________

Other exposures: ____

I have reviewed page 1-6 with parent/patient. ______________________________ Date____________

Physician / PA Signature

HIPAA Privacy Notice – Patient Acknowledgement
"Health Insurance Portability and Accountability Act"

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical record of your care remains the physical property of Colorado Allergy and Asthma Centers, P.C. The State of Colorado supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as; physician, medical practice, or to an insurance company for treatment, payment, and operations of CAAC.

Health Care Operations
There remain certain operational activities, where, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific occurrence by you. Some examples include:

- Requesting Photo ID at your visit
- Taking and saving a photograph of the patient for the chart to be used for identification and medical treatment
- Communicating with your pharmacy, insurance carrier, primary care provider, and other professionals involved in the patient's healthcare (such as schools, day care or college heath centers)
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office / reception staff call, text, or email you to schedule an appointment, acquire a referral, or to inform you about medications that may have to be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as lab or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours
- Discussing an opportunity to enroll you in ongoing Asthma Allergy Research; and/ or continuation in research studies/ clinical trials
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State or by Court Order. Please note that any unsecure electronic communication initiated by the patient/family is done so at their own risk

Your Rights under the Law:

You have the right to receive a notice about our privacy policy

The right to inspect your protected health information (PHI) with a provider in a private environment

The right to request a copy of PHI and to have returned to you in 30 days, unless notified in writing of 60-day return

The right to request a restriction on uses and disclosures of your protected health information

The right to request to receive confidential communications from the practice by alternative means or at an alternative location

The right to request an amendment of your protected health information

The right to request an accounting of disclosures of Protected Health Information (PHI)

The right to revoke or limit authorization

The right to be notified of a breach of your PHI

Please list by name and relation the person(s) that may receive messages or talk to us regarding patient's medical care.

______________________________	______________________________
Name/relation	Contact Number
______________________________	______________________________
Name/relation	Contact Number
______________________________	______________________________
Name/relation	Contact Number

Practice Duties
It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

Patient Name (label) ____

ACKNOWLEDGEMENT

I, ______________________________ (patient, responsible party), acknowledge that I have received a copy of Colorado Allergy and Asthma Centers P.C.'s (the practice's) "HIPAA Privacy Notice-Patient Acknowledgment" document regarding protection of Personal Health Information (PHI).

Patient's or Responsible Party's Signature ___________________________ Date ____________

You may request at any time a detailed written policy of the Colorado Allergy and Asthma Center's P.C., "HIPAA Privacy Notice- Detailed" or access it at www.coloradoallergy.com

Financial Policy

Please review this information and sign at the end of the document. By signing this document, the patient/responsibility party is accepting financial responsibility for all services provided.

Colorado Allergy and Asthma Centers (CAAC) will bill your insurance as a courtesy if the company is within the United States. We may provide an estimate of what your insurance company may pay. The insurance company makes the final determination of your eligibility and benefits.

It is your responsibility to notify our office of any patient information changes including address, name, and insurance information.

Insurance Accounts

1. I (patient or financially responsible party) will disclose all insurance information including primary and secondary insurance at the time of service. Failure to provide complete insurance information may result in my responsibility to pay the entire bill.
2. I agree to pay any portion of the charges not covered by my insurance within 10 days of the statement date. If CAAC is out of network with my insurance company, I will be responsible for any charges above what is paid by my insurance up to the CAAC set fee amount. If my insurance pays me directly, I agree to forward the payment to CAAC immediately.
3. I am responsible for any co-payments, co-insurances, deductibles, plus any balance due on non-covered services not paid by my insurance at the time of service. Payments are required within the state's time limitation for paying healthcare claims. The co-payment, co-insurance or deductible requirement cannot be waived. We accept cash, check or credit cards.

Self-Pay Accounts

If you do not have insurance or you choose to not utilize your insurance, we offer a self-pay discount of 25% if payment is received in full at the time of service. Self-pay accounts are for all services for the entire year, or until new insurance is initiated due to a qualifying event.
No Exceptions.

Referrals

1. I am responsible for obtaining a referral, if required by my policy.
2. I understand if I fail to obtain the referral and/or preauthorization there may be a lower payment or no payment from the insurance company. I will be responsible for the balance due.

Missed Appointments

I understand I may be charged a fee of $75.00 if I miss or cancel an appointment within 24 hours of the scheduled appointment.

Returned Checks

I understand I will be responsible for a fee of $35 for a returned check. This will be applied to my account in addition to the insufficient funds amount. All future payments must be paid with a debit/credit card or cash.

Medical Record Copies

I understand I will be responsible for a fee that follows Colorado Department of Health and Environment standard for requesting a copy of my health records.

Minor Patients

1. By signing this document, I (the parent, guardian) accept financial responsibility for all services provided by CAAC, regardless of who is the subscriber of the insurance policy.
2. I understand as the adult (parent, guardian) accompanying a minor, I am responsible for charges at time of service (such as co-payment or deductible).

A divorce decree does not determine which party Colorado Allergy and Asthma Centers, P.C. will bill for medical services. Divorce decrees are only binding upon the two parties who made the agreement.

Payments

1. I understand that I am requested to put a credit, debit or HSA card on file. This information is kept strictly confidential and will only be used for payment of fees to CAAC. The card on file will not be charged until the insurance company has reviewed the claim. By processing insurance first, patients will know their exact out-of-pocket responsibility. After the insurance company has completed processing the claim, I will receive an email informing them of the actual amount owed. The email will explain that the card on file will be charged in 3-5 days unless I contact the billing office at 720-858-7550.
2. I understand the Financial Information may be provided to the financially responsible party (Guarantor), Subscriber, or the party paying the bill.
3. I understand the financially responsible party (Guarantor) is responsible for payments
4. I understand upon default, I am responsible for 24% per annum interest, cost of collections, and attorney fees, even if no lawsuit is filed.

Extended payment arrangements are available if needed. Please contact an Account Manager in our Patient Finance Office at 720-858-7550 to discuss payment options.

Please call our Patient Finance Office at 720-858-7550 with any questions or concerns.

I have read the policies above and understand and agree to this Financial Policy.

____
PRINTED Name of Financially Responsible Party

____ ____________________________
Signature of Financially Responsible Party | Date

____ ____________________________
Witness (CAAC Employee) | Date

MEDICATION ALERT

For skin testing, **hold** any of the following medications or any other over-the-counter or prescription medication, containing an antihistamine, **for at least 7 days:**

Allegra (Fexofenadine)
Alavert (Loratadine)
Actifed
Antivert (Meclizine)
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Chlor-Trimeton (Chlorpheniramine)
Clarinex (Desloratadine)
Claritin (Loratadine)
Dallergy
Dimetane
Dimetapp
Doxepin (Silenor)
Dramamine
Duravent-DA
Pamprin Max Strength (Pyrilamine maleate)
Periactin (Cyproheptadine)
Phenergan (Promethazine)
Rondec
Sudafed Cold
Tavist (Clemastine)
Tylenol PM
Vertin (Meclizine)
Xyzal (Levoceterizine)
Zyrtec (Cetirizine)
Zzzquil (Diphenhydramine)

Any "PM," "Cold," or "Allergy" Medication

Eye drops: May contain Antihistamine:

Alamast
Alocril
Alomide
Bepreve
Elestat
Lastacaft
Naphcon-A
Optivar
Opcon-A
Pataday
Patanol
Pazeo
Zaditor
or OTC Brands

Nose Sprays Containing Antihistamine: Astelin (Azelastine), Astepro, Dymista, Patanase

7 Day Hold:

Axid (Nizatidine) Pepcid (Famotidine) Tagamet (Cimetidine) Zantac (Ranitidine)

Do not stop medication you have been prescribed for other chronic medical conditions, such as heart and lung problems, or inhaled medications for your chest or nose. Do not stop asthma medications. Do not stop Singulair.

Call prescribing doctor for instructions on holding the medications listed below. May interfere with skin testing. Hold for 5 days before appointment.

Antidepressants/Anti-psychotics:

Asendin (Amoxapine)
Ativan, Temesta, Tavor, Lorabenz (Lorazepam)
Desyrel, Oleptro (Trazodone)
Doxepin, Silenor Elavil (Amitriptyline)
Ludiomil (Maprotiline)
Medazepam (Nobrium)
Norpramin (Desipramine)
Pamelor (Nortriptyline)
Remeron (Mirtazapine)
Risperdal (Risperidone)
Rivotril, Klonopin (Clonazepam)
Seroquel (Quetiapine)
Surmontil (Trimipramine)
Tofranil (Imipramine)
Vistaril (Hydroxyzine)
Vivactil (Protriptyline)

Cogentin (benztropine): For Parkinson's Disease, antihistamine properties

Some tranquilizers, cough medications, and sleeping aids may contain an antihistamine.
If you have questions about the content of any medications, please call your doctor, pharmacist, or us.

4/2018